10. Dental services. (continued.)

Service	Limitation
Fixed cast metal restorations	When cost effective for recipients who cannot use removable dentures because of their medical condition, requires prior authorization. To be considered for prior authorization, the recipient must have less than four upper and four lower back teeth that meet and are in biting function unless the missing teeth are permanent teeth and the recipient has only bicuspid occlusion. A fixed bridge will be considered as a replacement for one or more front teeth.
Orthodontic treatment, except space maintainers	Requires prior authorization.
Services in excess of those listed above	Requires prior authorization.

B. The following dental services are not eligible for payment:

1) Full mouth of panoramic x-rays for a recipient under eight years of age unless prior authorized, or in the case of an emergency;

2) Base or pulp caps, direct or indirect;

3) Local anesthetic that is billed as a separate procedure;

4) Hygiene aids, including toothbrushes;

5) Medication dispensed by a dentist that a recipient is able to obtain from a pharmacy;

10. Dental services. (continued.)

6) Acid etch for a restoration that is billed as a separate procedure;

7) Periapical x-rays, if done at the same time as a panoramic or full mouth x-ray survey unless prior authorization is obtained;

8) Prosthesis cleaning;

9) Unilateral partial prosthesis involving posterior teeth; ~~and~~

10) Replacement of a denture when a reline or rebase would correct the problem;

11) Duplicate x-rays;

12) Crowns and bridges, unless the recipient has a documented medical condition that prohibits the use of a removable prostheses; and

13) Gold restoration or inlay, including cast nonprecious and semiprecious metals.

11. Physical therapy and related services.

See Items 11.a. through 11.c.

11.a. Physical therapy services.

Coverage is limited to:

(1) Services prescribed by a physician, physician assistant or nurse practitioner;

(2) Services provided by a physical therapist or a physical therapist assistant who is under the direction of a physical therapist;

(3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician, physician assistant or nurse practitioner at least once every 60 days;

(4) (A) Services that are rehabilitative and therapeutic and are provided to a recipient whose functional status is expected by the physician or nurse practitioner to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period; or

(B) Services that are specialized maintenance therapy provided to a recipient who cannot be treated only through rehabilitative nursing services because they have one of thefollowing conditionss:

(i) Spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care;
(ii) A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance movement patterns, activities of daily living, or positioning necessaryfor completionn of the recipient's activities of daily living;
(iii) An orthopedic condition that may lead to physiological deterioration and require therapy interventionn by a physical therapist to maintain strength, joint mobility and cardio-vascular function;

11.a. Physical therapy services. (continued)

(iv) Chronic pain that interferes with functional status and is expected by the physician to respond to therapy;
(v) Skin breakdown that requires a therapy procedure other than a rehabilitative nursing service.

Physical therapist is defined as a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent. Physical therapists must meet state licensure requirements when they are developed.

Physical therapist assistant is defined as one qualified under the rules of the Board of Medical Examiners. These rules define a physical therapist assistant as a skilled technical worker who is a graduate of a physical therapy assistant educational program accredited by the American Physical Therapy Association or a comparable accrediting agency. A physical therapist assistant performs selected physical therapy treatments and related duties as delegated by the physical therapist to assist the physical therapist in patient, client or resident related activities.

Direction is defined as the actions of a physical therapist who instructs the physical therapist assistant in specific duties to be performed, monitors the provision of services as the therapy assistant provides the services, is on premises not less than every sixth treatment session of each recipient when treatment is provided by a physical therapist assistant and meets the other supervisory requirements specified in the rules of the Board of Medical Examiners.

Coverage does *not* include:

(1) Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility;
(2) Ambulation of a recipient who has an established gait pattern.
(3) Services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be maintained by routine nursing measures.

11.a. Physical therapy services. (continued)

(4) Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide.
(5) Bowel and bladder retraining programs.
(6) Arts and crafts activities for the purposes of recreation.
(7) Services that are not documented in the recipient's health care record.
(8) Services that are not designed to improve or maintain the functional status of a recipient with a physical impairment.
(9) Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the recipient's individualized education plan.
(10) A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements.
(11) Evaluations or reevaluations performed by a physical therapist assistant.
(12) Services provided in a nursing facility, ICF/MR or day training and habilitation services centers, if the cost of physical therapy has been included in the facility's per diem.
(13) Services provided by a physical therapist other than the therapist billing for the services, unless the physical therapist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case the agency, facility or physician must bill for the service.
(14) Services provided by an independently enrolled physical therapist who is not Medicare certified.
(15) Services provided by an independently enrolled physical therapist who does not maintain an office at his or her expense.
(16) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

11.b. Occupational therapy services.

Coverage is limited to:

(1) Services prescribed by a physician, physician assistant or nurse practitioner;

(2) Services provided by an occupational therapist or an occupational therapy assistant who is under the direction of an occupational therapist;

(3) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician, physician assistant or nurse practitioner at least once every 60 days; and

(4) (A) Services that are rehabilitative and therapeutic and are provided to a recipient whose functional status is expected by the physician or nurse practitioner to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period; or

(B) Services that are specialized maintenance therapy provided to a recipient who cannot be treated only through rehabilitative nursing services because they have one of the following conditions:

(i) Spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care;

(ii) A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance movement patterns, activities of daily living, or positioning necessary for completion of the recipient's activities of daily living;

(iii) An orthopedic condition that may lead to physiological deterioration and require therapy intervention by an occupational therapist to maintain strength, joint mobility and cardiovascular function;

11.b. Occupational therapy services. (continued)

(iv) Chronic pain that interferes with functional status and is expected by the physician to respond to therapy;

(v) Skin breakdown that requires a therapy procedure other than a rehabilitative nursing service.

Occupational therapist is defined as an individual currently registered by the American Occupational Therapy Association as an occupational therapist.

Occupational therapy assistant is defined as an individual holding an associate degree in occupational therapy and who is currently certified by the American Occupational Therapy Certification Board as an occupational therapy assistant.

Direction is defined as the actions of an occupational therapist who instructs the occupational therapy assistant in specific duties to be performed, monitors the provision of services as the therapy assistant provides the service, and is on premises not less than every sixth treatment session of each recipient when treatment is provided by an occupational therapy assistant.

Coverage does *not* include:

(1) Services for contracture that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility.

(2) Ambulation of a recipient who has an established gait pattern.

(3) Services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be maintained by routine nursing measures.

(4) Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide.

(5) Bowel and bladder retraining programs.

(6) Arts and crafts activities for the purpose of recreation.

11.b. Occupational therapy services. (continued)

(7) Services that are not documented in the recipient's health care record.

(8) Services that are not designed to improve or maintain the functional status of a recipient with a physical impairment.

(9) Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the recipient's individualized education plan.

(10) A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements.

(11) Evaluations or reevaluations performed by an occupational therapy assistant.

(12) Services provided in a nursing facility, ICF/MR or day training and habilitation services center, if the cost of occupational therapy has been included in the facility's per diem.

(13) Services provided by an occupational therapist other than the therapist billing for the service, unless the occupational therapist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.

(14) Services provided by an independently enrolled occupational therapist who is not Medicare certified.

(15) Services provided by an independently enrolled occupational therapist who does not maintain an office at his or her own

(16) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

11.c. ~~Services for individuals with~~ Speech, language, and hearing ~~and language disorders hearing~~ therapy services (provided by or under the supervision of a speech pathologist or audiologist).

Coverage of **speech and language therapy services** is limited to:

(1) Services provided upon written referral by a physician, physician assistant or nurse practitioner or in the case of a resident of a long-term care facility on the written order of a physician as required by 42 CFR §483.45.

(2) Services provided by a speech language pathologist or a person completing the clinical fellowship year required for certification as a speech-language pathologist under the supervision of a speech-language pathologist.

(3) Services provided to a recipient whose functional status is expected by the physician or nurse practitioner to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period.

(4) For long term care recipients, services for which there is a statement in the clinical record every 30 days that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

(5) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician, physician assistant or nurse practitioner at least once every 60 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.